UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK
----------X
JUAN CABRERA,

Plaintiffs,

-against-

BOSTON SCIENTIFIC CORPORATION

Defendants,
----------X

EXCHANGE OF MEDICAL INFORMATION

Docket #: 07 Civ. 9935

PLEASE TAKE NOTICE, that the plaintiff, Juan Cabrera, by and through his attorneys, BONINA & BONINA, P.C., pursuant to Rule 26 of the Federal Rules of Civil Procedure serves upon you the following medical information:

1. A duly executed authorization allowing you to obtain and review the records of Medicaid, Department of Health, Corning Tower, Empire State Plaza, Albany, New York 12237 with regard to the plaintiff, **Juan Cabrera.**
2. A duly executed authorization allowing you to obtain and review the medical records of New York Presbyterian-Columbia University Medical Center, 622 West 168th Street, New York, New York 10032 with regard to the care and treatment of the plaintiff, **Juan Cabrera**.
3. A duly executed authorization allowing you to obtain and review the medical records of Dr. Yoshifumi Naka, M.D., PhD, c/o Columbia University Medical Center, 177 Fort Washington Avenue, Room 7-435, New York, New York 10032 with regard to the care and treatment of the plaintiff, **Juan Cabrera.**

4. A duly executed authorization allowing you to obtain and review the medical records of Dr. Allen S. Steward, M.D. c/o Columbia University Medical Center, 177 Fort Washington Avenue, Room 7-435, New York, New York 10032 with regard to the care and treatment of the plaintiff, **Juan Cabrera.**

5. A duly executed authorization allowing you to obtain and review the medical records of Dr. Goria Weisz, M.D., c/o New York Presbyterian-Columbia University Medical Center, 161 Fort Washington Avenue, New York, New York 10032 with regard to the care and treatment of the plaintiff, **Juan Cabrera.**

6. A duly executed authorization allowing you to obtain and review the ambulance records of E.M.S., New York City Area Office, New York State Department of Health, 90 Church Street, 15th Floor, New York, New York 10007 with regard to the plaintiff, **Juan Cabrera.**

7. A duly executed authorization allowing you to obtain and review the medical records of Dr. Jose A. Goris, M.D., 435 Fort Washington Avenue, Suite #1C, New York, new York 10033 with regard to the care and treatment of the plaintiff, **Juan Cabrera.**

Dated: Brooklyn, New York
January 11, 2008

I have read the foregoing and I certify that, upon information and belief, the source of which is the review of a file maintained by my office, that the foregoing Exchange of Medical Information is not frivolous as defined in subsection (c) of Section 130-1.1 of the Rules of the Chief Administrator.

AMY INSLER, ESQ.
BONINA & BONINA, P.C.
Attorneys for Plaintiffs
16 Court Street, Suite 1800
Brooklyn, New York 11241
718-522-1786

TO: CLERK OF THE COURT

Kaye Scholer, LLP
425 Park Avenue
New York, New York 10022-3598
(212) 836-8000
Attn: Angela Vicari, Esq.

OCA Official Form No.:

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name: **JUAN CABRERA**	Date of Birth: **02-24-1950**	Social Security Number: [redacted]**0**
Patient Address: **569 WEST 150TH STREET, APT. #5D, NEW YORK, NEW YORK 10031**		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted below in Item4), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE**

7. Name and address of health provider or entity to release this information: **ATTN: RECORDS DEPARTMENT MEDICAID- DEPARTMENT OF HEALTH, CORNING TOWER, EMPIRE STATE PLAZA, ALBANY, NEW YORK 12237**

8. Name and address of person(s) or category of person to whom this information will be sent: **KAYE SCHOLER, LLP - 425 PARK AVENUE - NEW YORK, NEW YORK 10022**

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ■ Other: **ENTIRE INSURANCE CLAIMS RECORDS**

Include: (Indicate by Initialing)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

10. Reason for release of information:	11. Date or event on which this authorization will expire:
X At request of individual ■ Other: **LEGAL REVIEW**	**AT THE CONCLUSION OF MY LEGAL MATTER**
12. If not the patient, name of person signing form: **BONINA & BONINA, P.C.**	13. Authority to sign on behalf of patient: **POWER OF ATTORNEY**

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

X Amy Insler Date: **JANUARY 11, 2008**

Signature of patient or representative authorized by law

BONINA & BONINA, P.C. by AMY INSLER, ESQ.

***Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

****This person or category of persons Is not limited to the attorney or governmental agency referred to In Item 9(b). That section refers only to persons who are authorized to discuss the health information forwarded by the providers.**

State of New York)
County of Kings) ss:

On the 11th day of January, 2008 before me personally came and appeared Amy Insler, Esq. known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that he/she executed same

Sandra Ferrari
Notary

SANDRA FERRARI
NOTARY PUBLIC, State of New York
No. 01FE6033290
Qualified in Kings County
Commission Expires November 15, 2009

POWER OF ATTORNEY

TO EXECUTE HIPAA MEDICAL RECORD AUTHORIZATION FORMS PURSUANT TO NY PUBLIC HEALTH LAW §18(1)(G) AS AMENDED 10/26/04

I, Juan Cabrera

of 569 West 150th Street Apt. #5D
(Insert your name and address)
New York, New York 10031

do hereby appoint: ***BONINA & BONINA, P.C.*** with offices at ***16 Court Street, Brooklyn, NY 11241***, my attorneys-in-fact to act (each agent may act separately) in my name, place and stead in any way which I myself could do, if I were personally present to execute HIPAA medical record authorization forms pursuant to NY Public Health Law §18(1)(g) as amended 10/26/04. This Power of Attorney may be revoked by me at any time. This Power of Attorney shall not be affected by my subsequent disability or incompetence.

To induce any third party to act hereunder, I hereby agree that any third party receiving a duly executed copy or facsimile of this instrument may act hereunder, and that revocation or termination hereof shall be ineffective as to such third party unless and until actual notice or knowledge of such revocation or termination shall have been received by such third party, and I for myself and for my heirs, executors, legal representatives and assigns, hereby agree to indemnify and hold harmless any such third party from and against any and all claims that may arise against such third party by reason of such third party having relied on the provisions of this instrument.

IN WITNESS WHEREOF, I have hereunto signed by name this 3 day of August, 20 07.

× Juan A Cabrera
(Signature)

ACKNOWLEDGMENT

STATE OF NEW YORK)
) ss:
COUNTY OF KINGS)

On this 3rd day of August, 20 07, before me the undersigned, personally appeared Juan Cabrera, personally known to be or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that (s)he executed the same in his/her capacity, and that by his signature on the instrument, the individual, or the person who acted on behalf of the individual, executed the instrument and that such individual made such appearance before the undersigned at Brooklyn, New York.

Sandra Ferrari
Notary

SANDRA FERRARI
NOTARY PUBLIC, State of New York
No. 01FE6033290
Qualified in Kings County
Commission Expires November 15, 2009

OCA Official Form No.:

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA
[This form has been approved by the New York State Department of Health]

Patient Name: **JUAN CABRERA**	Date of Birth: **02-24-1950**	Social Security Number: [redacted]**0**
Patient Address: **569 WEST 150TH STREET, APT. #5D, NEW YORK, NEW YORK 10031**		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted below in Item4), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE**

7. Name and address of health provider or entity to release this information: **ATTN: MEDICAL RECORDS DEPARTMENT NEW YORK PRESBYTERIAN-COLUMBIA UNIVERSITY MEDICAL CENTER, 622 WEST 168TH STREET, NEW YORK, NEW YORK 10032**

8. Name and address of person(s) or category of person to whom this information will be sent: **KAYE SCHOLER, LLP - 425 PARK AVENUE - NEW YORK, NEW YORK 10022**

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ■ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (Indicate by Initialing)
_____ Alcohol/Drug Treatment
_____ Mental Health Information
_____ HIV-Related Information

10. Reason for release of information:	11. Date or event on which this authorization will expire:
X At request of individual ■ Other: **LEGAL REVIEW**	**AT THE CONCLUSION OF MY LEGAL MATTER**
12. If not the patient, name of person signing form: **BONINA & BONINA, P.C.**	13. Authority to sign on behalf of patient: **POWER OF ATTORNEY**

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

X Amy Insler Date: **JANUARY 11, 2008**

Signature of patient or representative authorized by law

BONINA & BONINA, P.C. by AMY INSLER, ESQ.

***Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

****This person or category of persons Is not limited to the attorney or governmental agency referred to In Item 9(b). That section refers only to persons who are authorized to discuss the health information forwarded by the providers.**

State of New York)
County of Kings) ss:

On the 11th day of January, 2008 before me personally came and appeared Amy Insler, Esq. known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that he/she executed same

Sandra Ferrari
Notary

SANDRA FERRARI
NOTARY PUBLIC, State of New York
No. 01FE6033290
Qualified in Kings County
Commission Expires November 15, 2009

POWER OF ATTORNEY

TO EXECUTE HIPAA MEDICAL RECORD AUTHORIZATION FORMS PURSUANT TO NY PUBLIC HEALTH LAW §18(1)(G) AS AMENDED 10/26/04

I, Juan Cabrera

of 569 West 150th Street Apt. #5D
(Insert your name and address)
New York, New York 10031

do hereby appoint: ***BONINA & BONINA, P.C.*** with offices at ***16 Court Street, Brooklyn, NY 11241***, my attorneys-in-fact to act (each agent may act separately) in my name, place and stead in any way which I myself could do, if I were personally present to execute HIPAA medical record authorization forms pursuant to NY Public Health Law §18(1)(g) as amended 10/26/04. This Power of Attorney may be revoked by me at any time. This Power of Attorney shall not be affected by my subsequent disability or incompetence.

To induce any third party to act hereunder, I hereby agree that any third party receiving a duly executed copy or facsimile of this instrument may act hereunder, and that revocation or termination hereof shall be ineffective as to such third party unless and until actual notice or knowledge of such revocation or termination shall have been received by such third party, and I for myself and for my heirs, executors, legal representatives and assigns, hereby agree to indemnify and hold harmless any such third party from and against any and all claims that may arise against such third party by reason of such third party having relied on the provisions of this instrument.

IN WITNESS WHEREOF, I have hereunto signed by name this 3 day of August, 20 07.

× Juan A Cabrera
(Signature)

ACKNOWLEDGMENT

STATE OF NEW YORK)
) ss:
COUNTY OF KINGS)

On this 3rd day of August, 20 07, before me the undersigned, personally

appeared Juan Cabrera, personally known to be or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that (s)he executed the same in his/her capacity, and that by his signature on the instrument, the individual, or the person who acted on behalf of the individual, executed the instrument and that such individual made such appearance before the undersigned at Brooklyn, New York.

Sandra Ferrari
Notary

SANDRA FERRARI
NOTARY PUBLIC, State of New York
No. 01FE6033290
Qualified in Kings County
Commission Expires November 15, 2009

OCA Official Form No.:

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA
[This form has been approved by the New York State Department of Health]

Patient Name: **JUAN CABRERA**	Date of Birth: **02-24-1950**	Social Security Number: [redacted]**0**
Patient Address: **569 WEST 150TH STREET, APT. #5D, NEW YORK, NEW YORK 10031**		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted below in Item4), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE**

7. Name and address of health provider or entity to release this information: **ATTN: DR. YOSHIFUMI NAKA, M.D., PhD. COLUMBIA UNIVERSITY MEDICAL CENTER, 177 FORT WASHINGTON AVENUE, ROOM 7-435, NEW YORK, NEW YORK 10032**

8. Name and address of person(s) or category of person to whom this information will be sent: **KAYE SCHOLER, LLP - 425 PARK AVENUE - NEW YORK, NEW YORK 10022**

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ■ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other:_____

Include: (Indicate by Initialing)
_____ Alcohol/Drug Treatment
_____ Mental Health Information
_____ HIV-Related Information

10. Reason for release of information:	11. Date or event on which this authorization will expire:
X At request of individual ■ Other: **LEGAL REVIEW**	**AT THE CONCLUSION OF MY LEGAL MATTER**
12. If not the patient, name of person signing form: **BONINA & BONINA, P.C.**	13. Authority to sign on behalf of patient: **POWER OF ATTORNEY**

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

X Amy Insler Date: **JANUARY 11, 2008**

Signature of patient or representative authorized by law

BONINA & BONINA, P.C. by AMY INSLER, ESQ.

***Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

****This person or category of persons Is not limited to the attorney or governmental agency referred to In Item 9(b). That section refers only to persons who are authorized to discuss the health information forwarded by the providers.**

State of New York)
County of Kings) ss:

On the 11th day of January, 2008 before me personally came and appeared Amy Insler, Esq. known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that he/she executed same

Sandra Ferrari
Notary

SANDRA FERRARI
NOTARY PUBLIC, State of New York
No. 01FE6033290
Qualified in Kings County
Commission Expires November 15, 2009

POWER OF ATTORNEY

TO EXECUTE HIPAA MEDICAL RECORD AUTHORIZATION FORMS PURSUANT TO NY PUBLIC HEALTH LAW §18(1)(G) AS AMENDED 10/26/04

I, Juan Cabrera

of 569 West 150th Street Apt. #5D
(Insert your name and address)
New York, New York 10031

do hereby appoint: *BONINA & BONINA, P.C.* with offices at *16 Court Street, Brooklyn, NY 11241*, my attorneys-in-fact to act (each agent may act separately) in my name, place and stead in any way which I myself could do, if I were personally present to execute HIPAA medical record authorization forms pursuant to NY Public Health Law §18(1)(g) as amended 10/26/04. This Power of Attorney may be revoked by me at any time. This Power of Attorney shall not be affected by my subsequent disability or incompetence.

To induce any third party to act hereunder, I hereby agree that any third party receiving a duly executed copy or facsimile of this instrument may act hereunder, and that revocation or termination hereof shall be ineffective as to such third party unless and until actual notice or knowledge of such revocation or termination shall have been received by such third party, and I for myself and for my heirs, executors, legal representatives and assigns, hereby agree to indemnify and hold harmless any such third party from and against any and all claims that may arise against such third party by reason of such third party having relied on the provisions of this instrument.

IN WITNESS WHEREOF, I have hereunto signed by name this 3 day of August, 20 07.

× Juan A Cabrera
(Signature)

ACKNOWLEDGMENT

STATE OF NEW YORK)
) ss:
COUNTY OF KINGS)

On this 3rd day of August, 20 07, before me the undersigned, personally appeared Juan Cabrera, personally known to be or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that (s)he executed the same in his/her capacity, and that by his signature on the instrument, the individual, or the person who acted on behalf of the individual, executed the instrument and that such individual made such appearance before the undersigned at Brooklyn, New York.

Sandra Ferrari
Notary

SANDRA FERRARI
NOTARY PUBLIC, State of New York
No. 01FE6033290
Qualified in Kings County
Commission Expires November 15, 2009

OCA Official Form No.:

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA
[This form has been approved by the New York State Department of Health]

Patient Name: **JUAN CABRERA**	Date of Birth: **02-24-1950**	Social Security Number: [redacted]**0**
Patient Address: **569 WEST 150TH STREET, APT. #5D, NEW YORK, NEW YORK 10031**		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted below in Item4), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE**

7. Name and address of health provider or entity to release this information: **ATTN: DR. ALLEN S. STEWARD, M.D.. COLUMBIA UNIVERSITY MEDICAL CENTER, 177 FORT WASHINGTON AVENUE, ROOM 7-435, NEW YORK, NEW YORK 10032**

8. Name and address of person(s) or category of person to whom this information will be sent: **KAYE SCHOLER, LLP - 425 PARK AVENUE - NEW YORK, NEW YORK 10022**

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ■ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (Indicate by Initialing)
_____ Alcohol/Drug Treatment
_____ Mental Health Information
_____ HIV-Related Information

10. Reason for release of information:	11. Date or event on which this authorization will expire:
X At request of individual ■ Other: **LEGAL REVIEW**	**AT THE CONCLUSION OF MY LEGAL MATTER**
12. If not the patient, name of person signing form: **BONINA & BONINA, P.C.**	13. Authority to sign on behalf of patient: **POWER OF ATTORNEY**

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

X _____ Date: **JANUARY 11, 2008**
Signature of patient or representative authorized by law
BONINA & BONINA, P.C. by AMY INSLER, ESQ.

***Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or Infection and information regarding a person's contacts.**
****This person or category of persons Is not limited to the attorney or governmental agency referred to In Item 9(b). That section refers only to persons who are authorized to discuss the health information forwarded by the providers.**

State of New York)
County of Kings) ss:

On the 11th day of January, 2008 before me personally came and appeared Amy Insler, Esq. known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that he/she executed same

_____
Notary

SANDRA FERRARI
NOTARY PUBLIC, State of New York
No. 01FE6033290
Qualified in Kings County
Commission Expires November 15, 2009

POWER OF ATTORNEY

TO EXECUTE HIPAA MEDICAL RECORD AUTHORIZATION FORMS PURSUANT TO NY PUBLIC HEALTH LAW §18(1)(G) AS AMENDED 10/26/04

I, Juan Cabrera

of 569 West 150th Street Apt. #5D
(Insert your name and address)
New York, New York 10031

do hereby appoint: ***BONINA & BONINA, P.C.*** with offices at ***16 Court Street, Brooklyn, NY 11241,*** my attorneys-in-fact to act (each agent may act separately) in my name, place and stead in any way which I myself could do, if I were personally present to execute HIPAA medical record authorization forms pursuant to NY Public Health Law §18(1)(g) as amended 10/26/04. This Power of Attorney may be revoked by me at any time. This Power of Attorney shall not be affected by my subsequent disability or incompetence.

To induce any third party to act hereunder, I hereby agree that any third party receiving a duly executed copy or facsimile of this instrument may act hereunder, and that revocation or termination hereof shall be ineffective as to such third party unless and until actual notice or knowledge of such revocation or termination shall have been received by such third party, and I for myself and for my heirs, executors, legal representatives and assigns, hereby agree to indemnify and hold harmless any such third party from and against any and all claims that may arise against such third party by reason of such third party having relied on the provisions of this instrument.

IN WITNESS WHEREOF, I have hereunto signed by name this 3 day of August, 20 07.

× Juan A Cabrera
(Signature)

ACKNOWLEDGMENT

STATE OF NEW YORK)
) ss:
COUNTY OF KINGS)

On this 3rd day of August, 20 07, before me the undersigned, personally

appeared Juan Cabrera, personally known to be or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that (s)he executed the same in his/her capacity, and that by his signature on the instrument, the individual, or the person who acted on behalf of the individual, executed the instrument and that such individual made such appearance before the undersigned at Brooklyn, New York.

Sandra Ferrari
Notary

SANDRA FERRARI
NOTARY PUBLIC, State of New York
No. 01FE6033290
Qualified in Kings County
Commission Expires November 15, 2009

OCA Official Form No.:

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA
[This form has been approved by the New York State Department of Health]

Patient Name: **JUAN CABRERA**	Date of Birth: **02-24-1950**	Social Security Number: [redacted]**0**
Patient Address: **569 WEST 150TH STREET, APT. #5D, NEW YORK, NEW YORK 10031**		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted below in Item4), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE**

7. Name and address of health provider or entity to release this information: **ATTN: DR. GORIA WEISZ, M.D.**
NEW YORK PRESBYTERIAN - COLUMBIA UNIVERSITY MEDICAL CENTER, 161 FORT WASHINGTON AVENUE, NEW YORK, NY 10032

8. Name and address of person(s) or category of person to whom this information will be sent:
KAYE SCHOLER, LLP - 425 PARK AVENUE - NEW YORK, NEW YORK 10022

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ■ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other:_____

Include: (Indicate by Initialing)
_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

10. Reason for release of information:	11. Date or event on which this authorization will expire:
X At request of individual ■ Other: **LEGAL REVIEW**	**AT THE CONCLUSION OF MY LEGAL MATTER**
12. If not the patient, name of person signing form: **BONINA & BONINA, P.C.**	13. Authority to sign on behalf of patient: **POWER OF ATTORNEY**

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

X _____ Date: **JANUARY 11, 2008**
Signature of patient or representative authorized by law
BONINA & BONINA, P.C. by AMY INSLER, ESQ.

***Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or Infection and information regarding a person's contacts.**

****This person or category of persons Is not limited to the attorney or governmental agency referred to In Item 9(b). That section refers only to persons who are authorized to discuss the health information forwarded by the providers.**

State of New York)
County of Kings) ss:

On the 11th day of January, 2008 before me personally came and appeared Amy Insler, Esq. known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that he/she executed same

_____
Notary

SANDRA FERRARI
NOTARY PUBLIC, State of New York
No. 01FE6033290
Qualified in Kings County
Commission Expires November 15, 2009

POWER OF ATTORNEY

TO EXECUTE HIPAA MEDICAL RECORD AUTHORIZATION FORMS PURSUANT TO NY PUBLIC HEALTH LAW §18(1)(G) AS AMENDED 10/26/04

I, Juan Cabrera

of 569 West 150th Street Apt. #5D
(Insert your name and address)
New York, New York 10031

do hereby appoint: ***BONINA & BONINA, P.C.*** with offices at ***16 Court Street, Brooklyn, NY 11241***, my attorneys-in-fact to act (each agent may act separately) in my name, place and stead in any way which I myself could do, if I were personally present to execute HIPAA medical record authorization forms pursuant to NY Public Health Law §18(1)(g) as amended 10/26/04. This Power of Attorney may be revoked by me at any time. This Power of Attorney shall not be affected by my subsequent disability or incompetence.

To induce any third party to act hereunder, I hereby agree that any third party receiving a duly executed copy or facsimile of this instrument may act hereunder, and that revocation or termination hereof shall be ineffective as to such third party unless and until actual notice or knowledge of such revocation or termination shall have been received by such third party, and I for myself and for my heirs, executors, legal representatives and assigns, hereby agree to indemnify and hold harmless any such third party from and against any and all claims that may arise against such third party by reason of such third party having relied on the provisions of this instrument.

IN WITNESS WHEREOF, I have hereunto signed by name this 3 day of August, 20 07.

× Juan A Cabrera
(Signature)

ACKNOWLEDGMENT

STATE OF NEW YORK)
) ss:
COUNTY OF KINGS)

On this 3rd day of August, 20 07, before me the undersigned, personally

appeared Juan Cabrera, personally known to be or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that (s)he executed the same in his/her capacity, and that by his signature on the instrument, the individual, or the person who acted on behalf of the individual, executed the instrument and that such individual made such appearance before the undersigned at Brooklyn, New York.

Sandra Ferrari
Notary

SANDRA FERRARI
NOTARY PUBLIC, State of New York
No. 01FE6033290
Qualified in Kings County
Commission Expires November 15, 2009

OCA Official Form No.:

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA
[This form has been approved by the New York State Department of Health]

Patient Name: **JUAN CABRERA**	Date of Birth: **02-24-1950**	Social Security Number: [redacted]**0**
Patient Address: **569 WEST 150TH STREET, APT. #5D, NEW YORK, NEW YORK 10031**		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted below in Item4), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE**

7. Name and address of health provider or entity to release this information: **ATTN: AMBULANCE CALL RECORDS DEPARTMENT E.M.S., NEW YORK STATE DEPARTMENT OF HEALTH, 90 CHURCH STREET, 15TH FLOOR, NEW YORK, NEW YORK 10007**

8. Name and address of person(s) or category of person to whom this information will be sent: **KAYE SCHOLER, LLP - 425 PARK AVENUE - NEW YORK, NEW YORK 10022**

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ■ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (Indicate by Initialing)
_____ Alcohol/Drug Treatment
_____ Mental Health Information
_____ HIV-Related Information

10. Reason for release of information:	11. Date or event on which this authorization will expire:
X At request of individual ■ Other: **LEGAL REVIEW**	**AT THE CONCLUSION OF MY LEGAL MATTER**
12. If not the patient, name of person signing form: **BONINA & BONINA, P.C.**	13. Authority to sign on behalf of patient: **POWER OF ATTORNEY**

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

X Amy Insler Date: **JANUARY 11, 2008**

Signature of patient or representative authorized by law

BONINA & BONINA, P.C. by AMY INSLER, ESQ.

***Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

****This person or category of persons Is not limited to the attorney or governmental agency referred to In Item 9(b). That section refers only to persons who are authorized to discuss the health information forwarded by the providers.**

State of New York)
County of Kings) ss:

On the 11th day of January, 2008 before me personally came and appeared Amy Insler, Esq. known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that he/she executed same

Sandra Ferrari
Notary

SANDRA FERRARI
NOTARY PUBLIC, State of New York
No. 01FE6033290
Qualified in Kings County
Commission Expires November 15, 2009

POWER OF ATTORNEY

TO EXECUTE HIPAA MEDICAL RECORD AUTHORIZATION FORMS PURSUANT TO NY PUBLIC HEALTH LAW §18(1)(G) AS AMENDED 10/26/04

I, Juan Cabrera

of 569 West 150th Street Apt. #5D
(Insert your name and address)
New York, New York 10031

do hereby appoint: ***BONINA & BONINA, P.C.*** with offices at ***16 Court Street, Brooklyn, NY 11241***, my attorneys-in-fact to act (each agent may act separately) in my name, place and stead in any way which I myself could do, if I were personally present to execute HIPAA medical record authorization forms pursuant to NY Public Health Law §18(1)(g) as amended 10/26/04. This Power of Attorney may be revoked by me at any time. This Power of Attorney shall not be affected by my subsequent disability or incompetence.

To induce any third party to act hereunder, I hereby agree that any third party receiving a duly executed copy or facsimile of this instrument may act hereunder, and that revocation or termination hereof shall be ineffective as to such third party unless and until actual notice or knowledge of such revocation or termination shall have been received by such third party, and I for myself and for my heirs, executors, legal representatives and assigns, hereby agree to indemnify and hold harmless any such third party from and against any and all claims that may arise against such third party by reason of such third party having relied on the provisions of this instrument.

IN WITNESS WHEREOF, I have hereunto signed by name this 3 day of August, 20 07.

× Juan A Cabrera
(Signature)

ACKNOWLEDGMENT

STATE OF NEW YORK)
) ss:
COUNTY OF KINGS)

On this 3rd day of August, 20 07, before me the undersigned, personally appeared Juan Cabrera, personally known to be or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that (s)he executed the same in his/her capacity, and that by his signature on the instrument, the individual, or the person who acted on behalf of the individual, executed the instrument and that such individual made such appearance before the undersigned at Brooklyn, New York.

Sandra Ferrari
Notary

SANDRA FERRARI
NOTARY PUBLIC, State of New York
No. 01FE6033290
Qualified in Kings County
Commission Expires November 15, 2009

OCA Official Form No.:

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name: **JUAN CABRERA**	Date of Birth: **02-24-1950**	Social Security Number: [redacted]**0**
Patient Address: **569 WEST 150TH STREET, APT. #5D, NEW YORK, NEW YORK 10031**		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted below in Item4), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE**

7. Name and address of health provider or entity to release this information:
DR. JOSE A. GORIS, M.D., 435 FORT WASHINGTON AVENUE, SUITE #1C, NEW YORK, NEW YORK 10033

8. Name and address of person(s) or category of person to whom this information will be sent:
KAYE SCHOLER, LLP - 425 PARK AVENUE - NEW YORK, NEW YORK 10022

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ■ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other:_____

Include: (Indicate by Initialing)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

10. Reason for release of information:	11. Date or event on which this authorization will expire:
X At request of individual ■ Other: **LEGAL REVIEW**	**AT THE CONCLUSION OF MY LEGAL MATTER**
12. If not the patient, name of person signing form: **BONINA & BONINA, P.C.**	13. Authority to sign on behalf of patient: **POWER OF ATTORNEY**

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

X Amy Insler Date: **JANUARY 11, 2008**

Signature of patient or representative authorized by law

BONINA & BONINA, P.C. by AMY INSLER, ESQ.

***Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or Infection and information regarding a person's contacts.**

****This person or category of persons Is not limited to the attorney or governmental agency referred to In Item 9(b). That section refers only to persons who are authorized to discuss the health information forwarded by the providers.**

State of New York)
County of Kings) ss:

On the 11th day of January, 2008 before me personally came and appeared Amy Insler, Esq. known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that he/she executed same

Sandra Ferrari
Notary

SANDRA FERRARI
NOTARY PUBLIC, State of New York
No. 01FE6033290
Qualified in Kings County
Commission Expires November 15, 2009

POWER OF ATTORNEY

TO EXECUTE HIPAA MEDICAL RECORD AUTHORIZATION FORMS PURSUANT TO NY PUBLIC HEALTH LAW §18(1)(G) AS AMENDED 10/26/04

I, Juan Cabrera

of 569 West 150th Street Apt. #5D
(Insert your name and address)
New York, New York 10031

do hereby appoint: ***BONINA & BONINA, P.C.*** with offices at ***16 Court Street, Brooklyn, NY 11241***, my attorneys-in-fact to act (each agent may act separately) in my name, place and stead in any way which I myself could do, if I were personally present to execute HIPAA medical record authorization forms pursuant to NY Public Health Law §18(1)(g) as amended 10/26/04. This Power of Attorney may be revoked by me at any time. This Power of Attorney shall not be affected by my subsequent disability or incompetence.

To induce any third party to act hereunder, I hereby agree that any third party receiving a duly executed copy or facsimile of this instrument may act hereunder, and that revocation or termination hereof shall be ineffective as to such third party unless and until actual notice or knowledge of such revocation or termination shall have been received by such third party, and I for myself and for my heirs, executors, legal representatives and assigns, hereby agree to indemnify and hold harmless any such third party from and against any and all claims that may arise against such third party by reason of such third party having relied on the provisions of this instrument.

IN WITNESS WHEREOF, I have hereunto signed by name this 3 day of August, 20 07.

× Juan A Cabrera
(Signature)

ACKNOWLEDGMENT

STATE OF NEW YORK)
) ss:
COUNTY OF KINGS)

On this 3rd day of August, 20 07, before me the undersigned, personally appeared Juan Cabrera, personally known to be or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that (s)he executed the same in his/her capacity, and that by his signature on the instrument, the individual, or the person who acted on behalf of the individual, executed the instrument and that such individual made such appearance before the undersigned at Brooklyn, New York.

Sandra Ferrari
Notary

SANDRA FERRARI
NOTARY PUBLIC, State of New York
No. 01FE6033290
Qualified in Kings County
Commission Expires November 15, 2009

STATE OF NEW YORK, COUNTY OF ss.:

I, the undersigned, am an attorney admitted to practice in the courts of New York, and

Check Applicable Box

☐ Attorney's Certification — certify that the annexed has been compared by me with the original and found to be a true and complete copy thereof.

Attorney's Verification By Affirmation — say that: I am the attorney of record, or of counsel with the attorney(s) of record, for

☐ I have read the annexed and know the contents thereof and the same are true to my knowledge, except those matters therein which are stated to be alleged on information and belief, and as to those matters I believe them to be true. My belief, as to those matters therein not stated upon knowledge, is based on the following. The review of a file maintained in my office. The reason I make this affirmation instead of Plaintiffs is that Plaintiffs reside outside the county where my office is maintained.

affirm that the foregoing statements are true under penalties of perjury.

Dated:

(Print signer's name below signature)

STATE OF NEW YORK, COUNTY OF ss:

being sworn says: I am

Check Applicable Box

☐ Individual Verification — in the action herein; I have read the annexed know the contents thereof and the same are true to my knowledge, except those matters therein which are stated to be alleged on information and belief, and as to those matters I believe them to be true.

☐ Corporate Verification — the of a corporation, one of the parties to the action; I have read the annexed know the contents thereof and the same are true to my knowledge, except those matters therein which are stated to be alleged on information and belief, and as to those matters I believe them to be true.

My belief, as to those matters therein not stated upon knowledge, is based on the following:

Sworn to before me on , 200

(Print signer's name below signature)

STATE OF NEW YORK, COUNTY OF **KINGS** ss.:

Rosemarie Barraclough, being sworn says: I am not a party to the action, am over the age of 18 years of age and reside at **Brooklyn, New York**
On **January 11 2008** I served a true copy of the annexed **EXCHANGE OF MEDICAL INFORMATION** in the following manner:

Check Applicable Box

■ Service by Mail — by mailing the same in a sealed envelope, with postage prepaid thereon, in a post-office or official depository of the U.S. Postal Service within the State of New York, addressed to the last know address of the addressee(s) as indicated below:

☐ Personal Service — by delivering the same personally to the persons and at the addresses indicated below:

☐ Service by Electronic Means — by transmitting the same to the attorney by electronic means to the telephone number or other station or other limitation designated by the attorney for that purpose. In doing so I received a signal from the equipment of the attorney indicating that the transmission was received, and mailed a copy of same to that attorney, in a sealed envelope, with postage prepaid thereon, in a post office or official depository of the U.S. Postal Service within the State of New York, addressed to the last known address of the addressee(s) as indicated below:

☐ Overnight Delivery Service — by depositing the same with an overnight delivery service in a wrapper proper addressed. Said delivery was made prior to the latest time designated by the overnight delivery service for overnight delivery. The address and delivery service are indicated below:

Kaye Scholer, LLP
Attorneys for Defendant
425 Park Avenue
New York, New York 10022-3598
Attn: Angela Vicari, Esq.

Sworn to before me this day **January 11 2008**

Amy Insler

Amy Insler, Esq.

Rosemarie Barraclough

Rosemarie Barraclough

AMY L INSLER
NOTARY PUBLIC, State of New York
No. 02IN5073595
Qualified in Westchester County
Commission E...

AMY L INSLER
NOTARY PUBLIC, State of New York
No. 02IN5073595
Qualified in Westchester County
Commission Expires February 24, 2011

INDEX NO.:

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

JUAN CABRERA,

Plaintiffs,

-against-

BOSTON SCIENTIFIC CORPORATION,

Defendants,

EXCHANGE OF MEDICAL INFORMATION

BONINA & BONINA, P.C.
Attorneys for *Plaintiff(s)*
16 Court Street, Suite 1800
Brooklyn, NY 11241
Tele. No.: (718) 522-1786
Fax No.: (718) 243-0414

Pursuant to 22 NYCRR 130-1.1, the undersigned, an attorney admitted to practice in the courts of New York State, certifies that, upon information and belief and reasonable inquiry, the contentions contained in the annexed documents are not frivolous.

Dated: **January 11 2008**

Signature _____
Print Signer's Name: **AMY INSLER, ESQ.**

Service of a copy of the within *is hereby admitted.*

Dated:

_____
Attorney(s) for

PLEASE TAKE NOTICE

Check Applicable Box

☐ NOTICE OF ENTRY *that the within is a (certified) true copy of a entered in the office of the clerk of the within named Court on*

☐ NOTICE OF SETTLEMENT *that a of which the within is a true copy will be presented for settlement to the Hon. , one of the judges of the within named Court,* at Supreme, on ,

Dated:

BONINA & BONINA, P.C.
Attorneys for Plaintiff(s)
16 COURT STREET
BROOKLYN, N.Y. 11241